

MJA Careers

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Joining the docs

Telehealth is beginning to gather momentum in private practice. How are those already connected making it work?

On some days, Dr Ewen McPhee's clinic in the outback town of Emerald, Queensland, is more akin to a broadcast studio than a general practice.

On those days — roughly once a week — as many as 15 videoconferences take place between Dr McPhee's Central Queensland patients and their far-flung specialists.

The first take may be the regular paediatric telehealth clinic, when three or four children and their families speak with paediatrician Dr Michael Williams, who is based more than three hours' drive away in Mackay.

Afterwards, one of the practice's registrars may sit in for the pre- or post-op assessments via Skype with a Brisbane-based plastic surgeon.

Or Dr McPhee may pop his head in to provide further community information or medical details for a specialist in any one of 24 other fields the practice liaises with online.

Dr McPhee estimates that they

have facilitated as many as 200 such consultations within the past 12 months.

"Everyone seems very comfortable with it and especially when they realise they're not going to have to fly to Brisbane for a three-minute consult and then come back again", he says.

The telehealth numbers at McPhee Medical Group are at the very high end, but Dr McPhee is just one of an increasing number of doctors around the country who are beginning to take advantage of the technologies and initiatives encompassed by the term "telehealth", to try and improve the access to care for patients in rural and remote areas, Indigenous Australians and those in aged care.

Billing for Medicare Benefits Schedule (MBS) telehealth services by general practitioners more than doubled in the last year.

The absolute numbers are still not large — 5379 GP-facilitated videoconferences around the country

between January and March this year, up from 2268 the year before — but this is starting from zero when the MBS telehealth item numbers were first introduced on 1 July 2011.

The Royal Australian College of General Practitioners recently called for the telehealth services covered by the MBS to be significantly expanded to include patient-to-GP telehealth consultations in addition to the GP-facilitated patient-to-specialist services already listed.

The Australian College of Rural and Remote Medicine's (ACRRM) Telehealth Provider Directory now lists 525 general practice telehealth providers from Queensland's Charters Towers to Western Australia's Carnarvon.

For many, videoconferencing has been a new addition to older telehealth programs such as the ACRRM-run Telederm program, which provides a store-and-forward service for dermatology advice and education.

The value of these services was demonstrated recently when concern about a delay in the 2013 funding for Telederm sparked a vigorous social media response from rural GPs.

There was a rash of blog posts and tweets from IT-savvy GPs working in the remote reaches of Australia before, late last month, the Minister for Health Tanya Plibersek announced funding would continue.

In a field where the biggest factor governing cost-effectiveness is volume, the numbers are important.

When the government introduced the \$620 million telehealth program in the 2010 Budget, they planned to fund more than 495 000 consults by July 2015.

At the end of March this year — two years from the government deadline — just over 80 000 consults had occurred, and this allows for double counting the consultations in which both specialists and either GPs or Indigenous health

“Everyone seems very comfortable with it and especially when they realise they're not going to have to fly to Brisbane for a three-minute consult and then come back again”

” Dr Ewen McPhee

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workers and nurse practitioners took part.

The figures are moving in the right direction, but the movement is slow for a number of reasons.

Among those set up to offer telehealth, the use and capacity vary enormously.

While Dr McPhee has a high number of telehealth consults, others, such as Dr Tim Leeuwenburg, practising on South Australia's Kangaroo Island, carry out as few as just two videoconferences a month.

Dr Leeuwenburg used the original \$6000 Telehealth Onboard Incentive payment to acquire the audiovisual hardware and software required, but says one of the problems has been that many of the specialists he refers to — in particular those in the South Australian public hospital system — don't have compatible technology.

"The technology is a bit of a white elephant", he says. "It's very hard to do unless it's a follow-up appointment with somebody who is already in the private system."

Interoperability and connectivity remain a problem for everyone.

Without any coordination, different specialists have different IT systems requiring GPs to have different software for effective videoconferencing.

Because of this, and despite the generous onboard incentive payments, according to a recent ACRRM sample, the vast majority of telehealth consultations (88%) take place on Skype.

By their nature, such consultations are limited to the head and shoulders

view and so while ideal for psychiatry, they are unsuitable for patients requiring any form of examination.

Many doctors, such as Dr McPhee, have had to install a range of different software in order to communicate with the public system and different operators in the private realm.

Even if software compatibility problems can be overcome, the potential for telehealth to play a larger role in general practice is being sabotaged by problems with internet connectivity.

In this regard, the National Broadband Network comes in for particularly sharp criticism.

For those on the ground trying to implement telehealth, the fibre connections appear to be going to all the wrong places, bypassing aged care homes and medical centres.

It means that the cost of trying to ensure a secure connection — whether in outer Melbourne or Central Queensland — is significant and ongoing.

Those following telehealth, such as Dr Victoria Wade, a GP completing a PhD on its sustainability at the University of Adelaide, say these handicaps continue to prevent it from becoming a regular part of general practice and mean it is likely to take a much longer time to prove its cost-effectiveness.

"It's still very low volume. So because it's not fully integrated into routine practice, it's still taking extra time", Dr Wade says.

"Despite the extra 30% telehealth service fee and the incentive payment, many GPs are looking at it and saying it

still doesn't add up."

She says this is unlikely to be helped when the extra service incentive payments are reduced from \$32 to \$26 per consultation and the onboard incentive funding drops from \$3200 to \$2900 on 1 July this year, with incentives to end altogether on 1 July 2014.

Both Dr McPhee and Dr Leeuwenburg say the cuts will make it necessary for them to reconsider their commitment to telehealth.

Neither is confident that patients will be willing or able to bear an increased co-payment, despite the savings in travel, time and accommodation it offers.

But Vicki Sheedy, ACRRM strategic programs manager for eHealth, is more optimistic.

It's still in its infancy, she says, and can only make better business sense as better models of care are created.

"We see it still in its developmental stages. We think there's a lot of room for improvement. There's a lot of room for new models of care to emerge from it."

To that end, the College is now looking to work with specialists who are visiting rural communities, to see how telehealth can be used to optimise care between, during and after visits.

"To look at what really constitutes shared care using telehealth as a medium ... that's something we want to explore with other colleges, with our members and other telehealth users", Ms Sheedy says.

Meanwhile, on the morning we spoke, 20 000 feet above the South Australian coast Dr Leeuwenburg had encountered a patient on the same flight as he was taking to Adelaide.

The patient was flying to the mainland for a consultation with a specialist who, much to Dr Leeuwenburg's dismay, was still not equipped for telehealth.

"[The patient] knows that he's probably going to spend 10 minutes with that specialist", says Dr Leeuwenburg. "He will also have to pay for his airfare and taxi."

"Using telemedicine would probably have saved him lots of money and a nine-hour journey there and back!"

“ Despite the extra 30% telehealth service fee and the incentive payment, many GPs are looking at it and saying it still doesn't add up ”

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Project Rozana a worthy cause

Anglican Overseas Aid and Hadassah Australia are involved in a unique interfaith project improving health care for Palestinians.

When Associate Professor Julian Rait took over as chair of Anglican Overseas Aid on 1 March this year, he was already deeply involved in global public health initiatives.

Currently professor of ophthalmology at the University of Melbourne and chairman of medical defence organisation MDA National, Professor Rait has also been an affiliated physician with the Himalayan Cataract Project and the Nepal Glaucoma Eye Clinics Association, as well as working on blindness prevention in other developing countries.

So championing Anglican Overseas Aid's involvement in Project Rozana, a groundbreaking joint venture with the Hadassah Australia Foundation and the Hadassah Hospital in Jerusalem, was a no-brainer.

"This is a fantastic project", Professor Rait told the *MJA*.

"This is not just a purely medical venture, it's also an interfaith project", he said, referencing the involvement of the Jewish, predominantly Muslim Palestinian and Anglican Christian communities.

Project Rozana has three specific missions: to provide paediatric intensive care for Palestinian children with special acute medical needs at Hadassah Hospital; to train Palestinian doctors from the West Bank and Gaza Strip at Hadassah in specialties needed in their communities; and to train Palestinian mental health workers at Hadassah, specifically psychologists and trauma counsellors.

The project was born out of a three-month upskilling program for eight Palestinian psychologists that was sponsored by Hadassah Australia in 2011. The success of that led to a two-year certification program.

Further talks with Mr Izzat Abdulhadiir, the representative of the Palestinian Authority in Australia, led to a connection with Anglican

Overseas Aid, which was already active in Gaza with its breast cancer project, Women Die Waiting.

By November 2012, the president of Hadassah Australia, Ron Finkel, had met with the Palestinian Deputy Minister for Health, the ministry had subsequently approved Project Rozana, and a tripartite agreement between the three agencies had been signed.

Project Rozana is understood to be the first time that Australians can make a fully deductible donation to an overseas aid project where the beneficiaries are Palestinian, the funds are spent exclusively in an Israeli hospital, with the fundraising done by a combination of Jewish and Anglican national organisations.

Professor Rait is about to travel to Gaza to take part in an assessment of the progress of Project Rozana.

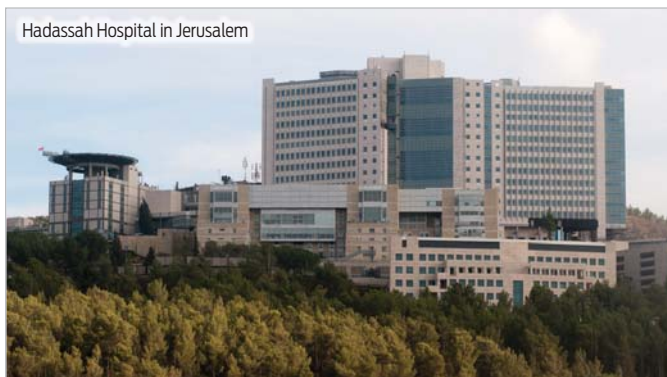
"I'll be heading over in August", he said. "We will be assessing to make sure that our efforts result in the improved care for Palestinians.

"Our aims are to deliver more doctors for the Palestinians, build capacity in Palestine, and reduce the burden of traumatic stress disorder and improve primary care", Professor Rait said.

Project Rozana is named after four-year-old Palestinian Rozana Ghannam. In May 2012, she fell from a ninth-floor balcony in Gaza, sustaining life-threatening injuries.

Her mother Maysa insisted Rozana be taken to Hadassah Hospital in the Israeli-controlled part of Jerusalem, acknowledged as the best paediatric intensive care unit in the Middle East, where Rozana was successfully treated.

"When we arrived at the checkpoint, I told the soldiers that Rozana must go to Hadassah Hospital. At Hadassah you are a human being, that's all", Maysa Ghannam has said. "You are a person without politics, without religion, without colour."



Hadassah Hospital in Jerusalem



Maysa Ghannam and daughter Rozana

ACT rejects AMSA plea over interns



Ben Veness

THE Chief Minister of the Australian Capital Territory, Katy Gallagher, has dismissed concerns about the ACT Health Directorate's decision to change the way medical internships are allocated at the Canberra Hospital.

Last month, the Health Directorate told Australian National University (ANU) medical students that they would no longer be given priority in the allocation of internships at the hospital if they simultaneously applied for positions at hospitals in other Australian states and territories.

The change in policy prompted the national president of the Australian Medical Students' Association, Ben Veness, to brand the move as "coercive, anti-competitive, and exploitative".¹

Last Wednesday, Mr Veness met with Chief Minister Gallagher in a bid to ease the pressure on the potential interns; with little success.

"It was a very disappointing meeting", Mr Veness told the *MJA*.

"The Chief Minister has absolutely no sympathy for the plight of these students.

"What concerns us is that this is such a convenient solution to the intern crisis for governments that it may set a precedent for other states and territories to follow."

Applications for internships were due on 7 June, with the first round of offers expected on 29 July.

Canberra Hospital offers more than 90 internships, and all ANU Medical School graduates are guaranteed a first-round offer, provided they do not apply elsewhere.

¹ Jean P. Limited options upset medical students. *Canberra Times* 2013; 22 May. <http://www.canberratimes.com.au/national/health/limited-options-upset-medical-students-20130521-2jzfx.html> (accessed Jun 2013).



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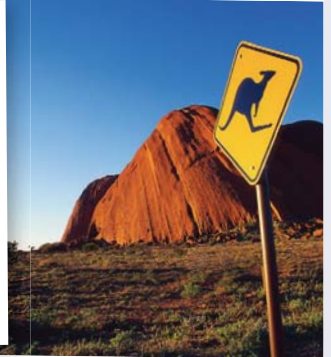
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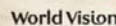
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